

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035698

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 183

FILED OCT 3 1962

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo.</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Polla</u>		c. CITY OR TOWN <u>ST. James</u>	
Length of stay in 1b <u>3 wks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Me Farland Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>—</u>	
HOSPITAL OR INSTITUTION		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>R.</u> Last <u>Woodring</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1892</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>Centralia, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Wm Wade</u>		13b. MOTHER'S MAIDEN NAME <u>Amand Sudlette</u>	
14. NAME OF HUSBAND OR WIFE <u>Lewis Woodring</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lewis Woodring - St James, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branch pneumonia</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. CITY, TOWN, OR LOCATION <u>—</u>		COUNTY <u>—</u>		STATE <u>—</u>	

21. I attended the deceased from <u>Aug 31 1962</u> to <u>Sept 20 1962</u> and last saw her alive on <u>Sept 20, 1962</u> Death occurred at <u>—</u> m of the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Dr. Anderson</u>	(Degree or title)
22b. ADDRESS <u>Polla Mo</u>	22c. DATE SIGNED <u>9/22/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-22-62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Soldiers Home Cem.</u>	23d. LOCATION (City, town, or county) <u>ST. James Mo.</u>
24. FUNERAL DIRECTOR <u>Prof E. L. Glickler</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 22, 1962</u>
26. REGISTRAR'S SIGNATURE <u>Nadene L. Stoll</u>	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

OCT 4 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by me Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Chas E Licklider

Licensed Embalmer No.

3546

P. O. Address

27 Ganges

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.